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DEPARTMENT OF HEALTH SERVICES

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MMCD Policy Letter 98-l 1

TO: [X] County Organized Health Systems Plans

[X] Prepaid Health Plans

[X] Primary Care Case Management Plans

[X] Two-Plan Model Plans

SUBJECT: FAMILY PLANNING SERVICES IN MEDI-CAL MANAGED CARE

PURPOSE

This policy letter is to provide clarification of out-of-plan family planning services for all Medi-Cal managed care health plans as specified in their contracts and defined in the Medi-Cal Managed Care Division (MMCD) Policy Letters 94-13 and 95-03 (see enclosed). After the issuance of the policy letters listed above, several issues and implementation problems were identified by the plans, as well as by out-of-plan family planning providers. The Department of Health Services (DHS) convened a work group to recommend further clarification to existing policies and contract requirements. The work group consists of plan representatives, family planning providers and clinics, and representatives from DHS Office of Family Planning and MMCD.

Family planning services are those specific services defined in MMCD Policy Letter 94-13 and 95-03 and its addendum. Under federal law, 1987 OBRA, Section 4113(c)(l)(B), "enrollment of an individual eligible for medical assistance in a primary care case management (PCCM) system, a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive such services under Section 1905(a)(4)(C)." Therefore, plan members must be allowed freedom of choice of family planning providers and may receive such services from any qualified family planning provider, including those out-of-plan, without prior authorization. All contracting managed care plans [County Organized Health Systems (COHS), Prepaid Health Plans (PHP), PCCM, and Two-Plan Model, hereafter referred to as the Plans] must comply with these provisions.

POLICY

Reimbursement

1. All contracting Plans must reimburse without prior authorization any qualified out-of-plan family planning provider who provides family planning services to Plan members. A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Section 5 1200 of Title 22.

2. The Plans must reimburse out-of-plan family planning providers for family planning services within the limitations set forth in the MMCD Policy Letters 94- 13 and 95-03. The office visit billing codes that must be reimbursed by the Plans are described in Attachment A.

3. In accordance with Title 22, Section 5 1305.4, Plans must receive a copy of the DHS approved sterilization consent form PM 330 from the out-of-plan family planning provider when a claim for tubal ligation or vasectomy is submitted. Plans are not required to obtain written consent for other contraceptive methods.

4. Plans must reimburse out-of-plan family planning providers when a claim is properly filled out in accordance with the Medi-Cal Inpatient/Outpatient Provider Manual guidelines.

5. Plans must comply with the Confidentiality of Medical Information Act, Civil Code, Section 56.10. Billing information may be disclosed by a health care provider to an insurer, health care service plan, governmental authority, or any other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment made. Patient authorization is not required for this disclosure. Once the information is disclosed to the Plan, the Plan has the responsibility to ensure that no further disclosure is made unless permitted by law or has been authorized by the patient. In particular, in the case of a patient who is a minor, the information must be managed in such a way that it is not disclosed to the minor's parent or legal guardian.

6. Plans must reimburse out-of-plan family planning providers at the applicable Medi-Cal rate appropriate to the provider type, as specified in Title 22, California Code of Regulations (CCR), Section 5 1501 et. seq. The fee-for-service (FFS)

Medi-Cal program has different reimbursement rates for specific services depending on the provider type rendering the service, e.g., physicians, licensed community clinics, and other organized outpatient clinics. Federally Qualified Health Care Centers must be reimbursed at their prevailing interim rates. All FFS reimbursement rates are subject to change. Plans may obtain details of Medi-Cal FFS reimbursement rates from the Inpatient/Outpatient Medi-Cal Manual, Title 22, or the quarterly Medi-Cal procedure file extracts (Report RF-o-500). If the claims cannot be priced using this information, Plans may obtain claims pricing assistance from the Electronic Data Systems (EDS) via fax at (916) 636-1287 in accordance with MMCD Policy Letter 98-08. Fax requests must be followed by a telephone call to (916) 636-1296 to verify that EDS has received sufficient information.

7. The Plan must reimburse all correctly completed claims within 45 days of receipt. Incomplete claims must be returned to the out-of-plan family planning provider within 45 days. Consistent with the Federal Balance Budget Act of 1997, a Plan shall ensure that 90 percent of clean claims for payment are paid within 30 calendar days of receipt. Plans are not responsible for reimbursing a completed out-of-plan claim initially received more than six months from the date of service.

8. Each Plan must have a provider appeal system, pursuant to Title 10, CCR, Section 1300.77.4 and the Health and Safety Code Section 1371, to address disputed claims. Plans must advise out-of-plan providers in writing of the process to appeal a denied claim.

9. Duplication of Services

   - Plans are not required to reimburse out-of-plan family planning providers for services that are duplicative and medically unnecessary. However, Plans must cooperate with out-of-plan family planning providers and understand that the risk of duplicating services is less important than facilitating timely access to family planning services. Plans must reimburse a duplicative service if there is documented medical necessity and if there are more than two documented attempts by the out-of-plan provider to contact the Plan for medical information.

   - Plans must have policies and procedures that provide for the timely exchange of medical information to the out-of-plan family planning provider when the release of information is authorized by the member.

10. Diagnosis and Treatment of Sexually Transmitted Diseases

- Plans must reimburse out-of-plan family planning providers for the diagnosis and treatment of sexually transmitted diseases (STD) during a family planning encounter.

- Plans must reimburse any qualified out-of-plan provider, including out-of-plan family planning providers, for the diagnosis and treatment of STDs within the limitations of MMCD Policy Letter 96-09, (see enclosed) and MMCD Policy Letter 94-13 and 95-03. Plans must reimburse out-of-plan providers for one visit for most of the common STDs.

- Plans must follow the latest STD guidelines recommended by the U.S. Public Health Service, Center for Disease Control as published in the most current Morbidity and Mortality Weekly Report (MMWR.).

11. HIV Counseling and Testing

- Plans must reimburse out-of-plan providers including out-of-plan family planning providers for HIV counseling and testing in accordance with MMCD Policy Letter 97-08 (HIV) and all State laws governing consent for testing and disclosure of HIV results (see enclosed).

12. Laboratory and Pharmacy Services

- Plans must reimburse out-of-plan family planning providers for laboratory and pharmacy services related to family planning as specified in the MMCD Policy Letter 94-13 and 95-03 (Family Planning). These services may either be provided on-site by the out-of-plan family planning provider or by an out-of-plan laboratory or pharmacy. The member's right to confidentiality for out-of-plan family planning services extends to use of out-of-plan laboratories and pharmacies. If confidentiality is not an issue, the out-of-plan family planning providers should direct a member to Plan contracted labs and pharmacies.

- Plans must reimburse contraceptive supplies dispensed by an out-of-plan family planning provider or pharmacy. In order to facilitate the member's compliance with the contraceptive method prescribed, Plans must pay for three months supply of contraceptives in one prescription if such quantity was prescribed by the provider whether in-plan or out-of-plan. This is consistent with the current reimbursement policy in the Medi-Cal FFS program. [Please see Pharmaceutical Services in Title 22, Section 51313(b).]

13. Pap Smear Periodicity

- Plans are required to follow the current U.S. Preventive Services Task Force (USPSTF) recommendations that require the performance of Pap smears for the detection of cervical cancer in women every one to three years based on the presence of risk factors. Risk factors are defined by the USPSTF as women with the onset of sexual activities before age 18, history of multiple sex partners, and women with HIV infection.

- Plans must reimburse out-of-plan family planning providers for Pap smears that are medically necessary for a family planning visit. Plans will not be required to reimburse out-of-plan family planning providers for Pap smears already performed by a Plan provider in accordance with the USPSTF guidelines, unless the out-of-plan family planning provider has documented two attempts to contact the Plan provider requesting medical information, and has failed to receive this information.

- Plans are required to follow up on abnormal Pap smears reported with a result of cervical intraepithelial neoplasia or more invasive lesions. Plans are not required to reimburse out-of-plan providers for the follow-up of these results unless there is prior authorization by the member's Plan or primary care provider.

14. Pregnancy Testing and Counseling Only Services

- Plans must reimburse out-of-plan family planning providers for pregnancy testing and counseling services when performed by trained personnel under the supervision of a licensed physician.

- All clinical, educational, and other personnel providing education and counseling (in-plan and out-of-plan) must be knowledgeable about the psychosocial and medical aspects of reproductive health, principles of behavioral change, and counseling techniques, including interviewing and communication skills. Providers must recognize situations where more intensive psychosocial counseling may be required and make referrals as appropriate.

15. Complications Related to Family Planning Services

- Plans must reimburse out-of-plan family planning providers for outpatient services related to complications clearly and directly resulting from family planning methods without prior authorization. Reimbursement is limited to no more than two outpatient office visits. More than two outpatient office visits and specific procedures, e.g., ultrasound, require prior authorization from the member's Plan.

- Plans must reimburse out-of-plan family planning providers for outpatient office visits to manage minor problems from hormonal methods of birth control, e.g., breakthrough bleeding from Depo-Provera, oral contraceptives, or Norplant. These outpatient office visits are exemptions to the two visit limitation and are not subject to prior authorization.

- Plans are accountable for all prior authorization decisions affecting their members. It is expected that authorization decisions will be based on medical necessity, but also take into consideration the member's possible transportation, confidentiality issues, and compliance problems. All decisions must be made in the best interest of the member. Plans must implement policies and procedures to ensure member follow-up and to continuously monitor the quality of prior authorization decisions. Consistent with Title 10, Section 1300.67.3, medical decisions made by a Plan must not be unduly influenced by fiscal and administrative management issues.

- Plans must reimburse out-of-plan family planning providers for emergency services provided in the outpatient office setting.

<u>Member Information</u>

1. Plans must educate members on the importance of family planning and their right to confidential services both in-plan and out-of-plan.

2. In accordance with Title 22, Section 53895(a) and Section 5388 l(b)(1 1)(15), Plans must send to all members, within seven days of enrollment, a member services guide which must include:

- Information explaining their right to receive family planning services from any qualified provider in-plan and out-of-plan, without prior authorization and procedures for accessing these services.

- Information on minor consent services available through the Plan.

- A description of the limitations on the family planning services members may seek outside the Plan.

Confidentiality and Sensitive Services for Minors

1. Plans must implement and maintain policies and procedures to ensure the right of all members, including minors, to have ready access to confidential sensitive services.

    - In accordance with California Family Code, Section 6925, and et. seq. and Title 22, 50063.5, parental consent is not required for members under the age of 18 to access pregnancy-related services, including family planning. Parental consent is not required of minors 12 years or older to obtain medical care related to the diagnosis and treatment of sexually transmitted diseases.

2. Individual medical records of Plan members cannot be released without the written consent of the member unless it is for the purpose of the exchange of information between individuals or institutions providing care, fiscal intermediaries, and State or local official agencies in accordance with Title 22, Section 5 1009.

3. Plans must implement and maintain policies and procedures to ensure that the medical and billing records of minors and adults relating to pregnancy, family planning, and STDs are handled in a strictly confidential manner. Policies and procedures for the maintenance of all patient records and consents for the release of medical information must conform to the Confidentiality of Medical Information Act, Civil Code, Section 56, et. seq., the Insurance Information and Privacy Protection Act, California Insurance Code, Sections 79 1, et. seq., and Title 22, Section 5 1009.

4. Special precautions must be taken to insure that communication regarding the medical information of a minor related to sensitive services is protected, i.e.,

letters and phone calls should not be directed to the home without the minor's authorization.

Memorandum of Understanding with Local Health Denartment Familv Planning Clinics

Plan must execute a subcontract with the Local Health Department family planning clinic if the Plan contract with DHS has this requirement. The subcontract will specify the scope and responsibilities of both parties, regarding billing reimbursements, reporting responsibilities, and medical record management to ensure coordinated health care services. These services include, but are not limited to, family planning services, HIV counseling and testing, and STD services.

DISCUSSION

Out-of-Plan Family Planning Providers

An out-of-plan family planning provider is a qualified provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to a member as specified in Title 22, Section 5 1200. An out-of-plan provider is a provider who is not employed by, under contract with, or otherwise affiliated with the Plan for authorized referral services.

Out-of-plan family planning providers are encouraged to seek contractual arrangements with the Plans in their service area and become an in-plan provider (a network provider). A list of DHS contracted Plans is available from the MMCD. Out-of-plan family planning providers are encouraged to contact the Plans in their area to discuss billing arrangements to facilitate reimbursement.

The provision of optimal family planning services to members of a managed care plan can be maximized by establishing effective coordination of care between the out-of-plan family planning provider and the primary care provider. It is essential that the out-of-plan family planning provider discuss with the Plan member the importance of coordination of care, and seek the member's authorization to release medical information to the primary care provider as appropriate. The out-of-plan family planning provider should refer the Plan member back to the Plan or primary care provider when it is in the best interest of the member's health care.

Reimbursement

1. Out-of-plan family planning providers must submit their family planning related claims to the member's Medi-Cal Plan for reimbursement. Medical records must clearly identify the person rendering services, including name and title. Nonphysician medical practitioner records must include the countersignature of the supervising physician in accordance with Title 22, Section 5 1476.

2. Out-of-plan family planning providers will only be reimbursed for family planning services provided in accordance with the MMCD Family Planning Policy Letters 94-l 3 and 95-03. The out-of plan family planning provider will only be reimbursed for the office visit codes listed on Attachment A.

3. The out-of-plan family planning provider does not need prior authorization by a Plan for a claim for family planning services except when more than two outpatient office visits are required for complications directly linked to family planning services.

4. All claims must be completed on a Health Care Financing Administration (HCFA) 1500 or UB92 in accordance with the billing requirements in the Medi-Cal Inpatient/Outpatient Provider Manual. A copy of the State-approved sterilization consent form, PM330 for tubal ligation or vasectomy must be submitted with claims for sterilization.

5. In accordance with the Confidentiality of Medical Information Act, Civil Code, Section 56.10, sufficient medical information must be disclosed by an out-of-plan family planning provider to the Plans to the extent necessary to allow responsibility for payment to be determined and amount of payment to be made. Patient authorization is not required for this disclosure.

6. Out-of-plan family planning providers are entitled to be reimbursed for all correctly completed claims within 45 days of receipt by the Plan. Consistent with the Federal Balance Budget Act of 1997, a Plan shall ensure that 90 percent of clean claims for payment are paid within 30 calendar days of receipt. Out-of-plan family planning providers shall not submit a claim for service more than six months from the date of service.

7. Problems with reimbursement for family planning, HIV counseling and testing, and STD diagnosis and treatment should be referred to the provider appeals system of the member's Plan. If this does not resolve the claim dispute, the

out-of-plan family planning provider can contact the Plan's contract manager at MMCD.

8. Duplication of Services

- Out-of-plan family planning providers will be reimbursed by the Plans only for family planning services that are not duplicative of services already provided by the member's Plan or primary care provider. The out-of-plan family planning provider must perform thorough screening of the Plan member to determine the medical necessity of services such as Pap smears and must document at least two attempts to contact the Plan or Plan provider for medical information when indicated.

- Out-of-plan family planning providers must have policies and procedures that provide for the timely exchange of medical information to the member's Plan or PCP when authorized by the member.

9. Diagnosis and Treatment of STD

- Out-of-plan family planning providers may bill the Plan for the diagnosis and treatment of STD made during a family planning encounter.

- Out-of-plan family planning providers may bill the Plan for the diagnosis and treatment of a STD only visit within the limitations of the MMCD Policy Letter 96-09 (see enclosed). An out-of-plan provider will be reimbursed for one visit for most of the common STDs. Follow-up visits for the sole purpose of treatment of STDs must be authorized by or referred back to the Plan.

- Out-of-plan family planning providers must follow the latest STD Guidelines recommended by the U.S. Public Health Service, Center for Disease Control as published in the most current MMWR.

10. HIV Counseling and Testing

- Out-of-plan family planning providers may submit a claim to a member's managed care plan for the provision of HIV counseling and testing services.

- Out-of-plan family planning providers must bill the member's Plan for HIV counseling and testing services according to the MMCD Policy Letter 97-08 and all State laws governing consent for testing and disclosure of HIV results (see enclosed).

- Out-of-plan family planning providers must refer Plan members who are diagnosed HIV positive to their primary care provider.

- Copies of the medical records must be forwarded to the primary care provider if authorized by the member.

11. Laboratory and Pharmacy Services

- If confidentiality and access are not barriers to care, the out-of-plan family planning provider should refer the member to pharmacies and laboratories contracted by the member's Plan.

- Out-of-plan family planning providers may submit claims to the member's Plan for laboratory services that are typically performed in the provider's office or sent out to a selected lab, e.g., Pap smears or testing for STDs.

- Out-of-plan family planning providers may bill the Plan for contraceptive supplies dispensed by a family planning provider. When a provider, whether in-plan or out-of-plan, prescribes or dispenses three months of contraceptive supplies, the Plan must pay for three months supply. This will facilitate patient compliance with the contraceptive method prescribed.

12. Pap Smear Periodicity

- Out-of-plan family planning providers may perform Pap smears when medically necessary and only during a visit for family planning services. Out-of-plan family planning providers will not be reimbursed for Pap smears already performed by a Plan provider in accordance with U.S. PSTF guidelines unless the out-of-plan family planning provider documents medical necessity and two failed attempts to contact the Plan provider requesting medical information. U.S. PSTF guidelines recommend the performance of Pap smears for the detection of cervical cancer in women every one to three years based on the presence of risk factors. Risk factors are defined by the U.S. PSTF as women with the onset of sexual activities before age 18, history of multiple sex partners, and women with HIV infection.

- Out-of-plan family planning providers will not be reimbursed for the follow-up of abnormal Pap smear results such as cervical intraepithelial neoplasia or more invasive lesions, unless there is prior authorization by the member's Plan or primary care provider.

13. Pregnancy Counseling and Testing

- Out-of-plan family planning providers may provide pregnancy counseling and testing by trained personnel under policies and procedures established by the out-of-plan provider and supervised by a licensed physician. All clinical, educational, and other personnel providing education and counseling must be knowledgeable about the psychosocial and medical aspects of reproductive health, principles of behavioral change, and counseling techniques, including interviewing and communication skills. Providers must recognize situations where more intensive psychosocial counseling may be required and make referrals as appropriate.

- All medical services must be performed under the supervision of a licensed physician.

- Pregnancy testing and counseling by an out-of-plan family planning provider must be provided in accordance with the required elements outlined in Attachment B.

- Billing codes for pregnancy testing and counseling only visits must include the appropriate evaluation and management codes as defined by the Physician's Current Procedural Terminology Code Book and the Medi-Cal Inpatient/Outpatient Manual (see Attachment A).

- Plan members with positive pregnancy tests must be referred back to their Plan for follow-up.

- A copy of the pregnancy test and counseling documentation should be forwarded to the primary care provider if authorized by the member.

14. Complications Related to Family Planning Services

- Out-of-plan family planning providers who provide services to Plan members are strongly encouraged to discuss and document the arrangements and responsibilities for medical management of unusual contraceptive complications with the Plans in their area.

- Out-of-plan family planning providers must inform a Plan member about the possibility of referral back to the Plan or primary care provider for the treatment of unusual complications of a family planning method, especially when the member has concerns about confidentiality.

- The out-of-plan family planning provider may provide outpatient office visit services related to complications clearly and directly resulting from family planning methods for a maximum of two outpatient office visits without prior authorization. Reimbursement for more than two outpatient office visits and specific procedures, e.g., ultrasound, requires prior authorization from the managed care Plan.

- Outpatient office visit services to manage minor problems from hormonal methods of birth control, e.g., breakthrough bleeding from Depo-Provera, oral contraceptives, or Norplant are an exemption from the two visit limitation and are not subject to prior authorization.

- Out-of-plan family planning providers should document that a Plan member has received education and counseling regarding the importance of coordination of care with their primary care provider and the member has been given the opportunity to authorize the transfer of medical information to the member's primary care provider.

- Emergency services do not require prior authorization from the member's Plans.

- Consent for release of medical information should be obtained from a member and the medical records promptly forwarded to the Plan or primary care provider when a member requires referral back to their Plan provider.

If you have any questions regarding this policy letter, please contact your contract manager.

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

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ATTACHMENT A

BILLING CODES FOR OUT-OF-PLAN FAMILY PLANNING OFFICE VISITS

FAMILY PLANNING VISIT TYPE	EVALUATION MANAGEMENT CODES	COMMENTS
FOCUSED VISIT (NEW PATIENT)	9920 1	Billed for an evaluation and management which requires three key components: • problem focused history • problem focused exam • straight forward medical decision making Example: Pregnancy testing and counseling for a new patient.
EXPANDED VISIT (NEW PATIENT)	99202	Requires three key components: • expanded problem focused history • expanded problem focused exam • straightforward medical decision making Example: Evaluation and management of a problem with a contraceptive method for a new patient.
DETAILED VISIT (NEW PATIENT)	99203	Requires three key components: • a detailed history • a detailed examination • medical decision making of low complexity Example: Female desiring counseling, evaluation and initiation of contraception.
MINIMAL VISIT (ESTABLISHED PATIENT)	99211	May not require the presence of a physician. Example: Uncomplicated visit for pregnancy testing and counseling, a simple pill refill or Depo-Provera counseling and injection.
FOCUSED PROBLEM (ESTABLISHED PATIENT)	99212	Requires two out of three key components: • problem focused history • problem focused exam • straight forward medical decision making Example: Evaluation of vaginal itching.
EXPANDED VISIT (ESTABLISHED PATIENT)	99213	Requires at least two of three key components: • expanded problem focused history • expanded problem focused examination • medical decision making of low complexity Example: Annual history and physical focused on Reproductive health.

ATTACHMENT B

REQUIRED ELEMENTS OF A PREGNANCY TESTING AND COUNSELING ONLY VISIT

1. Name, date of birth, and date of service.

2. Pregnancy history, i.e., gravida/para, date of most recent pregnancy.

3. Menstrual History.

4. Sexual history including contraceptive use.

5. Presenting pregnancy symptoms.

6. Current medications and identification of any significant teratogens.

7. Dates of prior pregnancy testing (including home tests) and results.

8. A member with a positive pregnancy test result requires education and counseling about all options available to the member including termination, adoption, and continuation of pregnancy. Members, with a positive pregnancy test, must be referred back to their Plan or primary care provider.

9. When the member is considering continuing the pregnancy; education and counseling must be given on the importance of early prenatal care; avoidance of substances that may be harmful to the fetus and referred back to their Plan for obstetrical care.

10. A member with a negative pregnancy test result requires education and counseling about preconception care, family planning services, risk reduction for pregnancy, and the need for repeat pregnancy testing as appropriate.

11. Signed release or refusal to release information to the enrollee's primary care provider or Plan.

12. Signature and title of personnel providing the service, and counter signature of the supervising physician.